

Exhibit #4

ILLINOIS DEPARTMENT OF CORRECTIONS

Administrative Review Board
Return of Grievance or Correspondence

Offender: Gharrett David M 38621
Last Name First Name MI ID#

Facility: Pontiac

☒ Grievance: Facility Grievance # (if applicable) _____ Dated: 11/3/17 or ☐ Correspondence Dated: _____
3/20/17
Received: 11/9/17 Regarding: failure to protect (nov 2016) @ men
no response to griev filed

The attached grievance or correspondence is being returned for the following reasons:

Additional information required:

- ☐ Provide your original written Offender's Grievance, DOC 0046, including the counselor's response, if applicable.
- ☐ Provide a copy of the Response to Offender's Grievance, DOC 0047, including the Grievance Officer's and Chief Administrative Officer's response, to appeal; if timely.
- ☐ Provide dates when incidents occurred.
- ☐ Unable to determine nature of grievance or correspondence; submit additional specific information. Please return the attached grievance or correspondence with the additional information requested to: Administrative Review Board
Office of Inmate Issues
1301 Concordia Court, Springfield, IL 62794-9277

Misdirected:

- ☐ Contact your correctional counselor or Field Services regarding this issue.
- ☐ Request restoration of Statutory Sentence Credits to Adjustment Committee. If the request is denied by the facility, utilize the offender grievance process outlined in Department Rule 504 for further consideration.
- ☐ Contact the Record Office with your request or to provide additional information.
- ☐ Personal property and medical issues are to be reviewed at your current facility prior to review by the Administrative Review Board.
- ☐ Address concerns in a letter to: Illinois Prisoner Review Board, 319 E. Madison St., Suite A, Springfield, IL 62706

No further redress:

- ☐ Award of Supplemental Sentence Credits are discretionary administrative decisions; therefore, this issue will not be addressed further.
- ☐ Administrative Transfer denials are discretionary administrative decisions; therefore, this issue will not be addressed further.
- ☒ Not submitted in the timeframe outlined in Department Rule 504; therefore, this issue will not be addressed further.
- ☐ Administrative Review Board received the appeal 30 days past date of Chief Administrative Officer's decision; therefore, this issue will not be addressed further.
- ☒ This office previously addressed this issue on 8/11/2015 (PC Denial)
Date
- ☐ No justification provided for additional consideration.

Other (specify): at Pontiac since 2/1/17

Completed by: Sherry Benton S. Benton 11/13/17
Print Name Signature Date

Exhibit #5

One Advantage, LLC
7650 MAGNA DRIVE
BELLEVILLE, IL 62223
(866) 812-3874

See Reverse Side for Account Detail

DAVID GHARRETT
PO BOX 1000
MENARD, IL 62259-0100

Dear DAVID GHARRETT,

The above referenced account(s) has been placed with our company for collection. Please send the balance to One Advantage, LLC or contact us at (866) 812-3874.

One Advantage, LLC reports this creditor's accounts with balances of \$50.00 or greater to one or more credit bureaus. However, if the balance is paid by 04/22/18, this account will not be reported. The Fair Credit Reporting Act prohibits One Advantage from reporting any disputed debt. Please refer to your right to dispute the validity of this debt in the last paragraph below.

Please send your payment to the remit address shown below. The creditor account number(s) should be noted on all correspondence and payments to ensure the proper handling and processing of your account(s).

PLEASE CALL OUR OFFICE AT (866) 812-3874

Office Hours (Central Time Zone)
MONDAY - THURSDAY 8:00 A.M. - 6:30 P.M.
FRIDAY 8:00 A.M. - 4:45 P.M.

Send correspondence to: One Advantage, LLC 7650 MAGNA DRIVE, BELLEVILLE IL 62223

For online payment options please go to <http://paybelleville.oneadvantagellc.com>

THIS COMMUNICATION IS FROM A DEBT COLLECTOR. THIS IS AN ATTEMPT TO COLLECT A DEBT AND ANY INFORMATION OBTAINED WILL BE USED FOR THAT PURPOSE.

Nothing in this letter affects or otherwise alters your rights described in the following paragraph:

UNLESS YOU NOTIFY THIS OFFICE WITHIN 30 DAYS AFTER RECEIVING THIS NOTICE THAT YOU DISPUTE THE VALIDITY OF THIS DEBT OR ANY PORTION THEREOF, THIS OFFICE WILL ASSUME THIS DEBT IS VALID. IF YOU NOTIFY THIS OFFICE IN WRITING WITHIN 30 DAYS AFTER RECEIVING THIS NOTICE THAT YOU DISPUTE THE VALIDITY OF THIS DEBT OR ANY PORTION THEREOF, THIS OFFICE WILL OBTAIN VERIFICATION OF THE DEBT OR OBTAIN A COPY OF A JUDGMENT AND MAIL YOU A COPY OF SUCH JUDGMENT OR VERIFICATION. IF YOU REQUEST THIS OFFICE IN WRITING WITHIN 30 DAYS AFTER RECEIVING THIS NOTICE, THIS OFFICE WILL PROVIDE YOU WITH THE NAME AND ADDRESS OF THE ORIGINAL CREDITOR, IF DIFFERENT FROM THE CURRENT CREDITOR.

Page 1 of 2

NOTICE: SEE REVERSE SIDE FOR IMPORTANT INFORMATION

MED-17300/BC1111- 213624974811

One Advantage, LLC • 7650 Magna Drive • Belleville, IL 62223 BC1111

2138/0001069/0005

7650 MAGNA DRIVE
BELLEVILLE, IL 62223

☐ Please check box if below address is incorrect or insurance information has changed, and indicate change(s) on reverse side.

PLEASE DETACH AND RETURN BOTTOM PORTION WITH YOUR PAYMENT

17149793 IF PAYING BY CREDIT CARD, FILL OUT BELOW.		
CHECK CARD USING FOR PAYMENT		
<input type="checkbox"/> VISA <input type="checkbox"/> MasterCard		
CARD NUMBER	CCV# (last 3 digits on back of card)	
SIGNATURE	XXXXXXXXXX	
EXP. DATE		
STATEMENT DATE	PAY THIS AMOUNT	ACCOUNT #
10/27/17	\$121.20	6157116
SHOW AMOUNT PAID HERE \$		

ADDRESSEE:



DAVID GHARRETT
PO BOX 1000
MENARD, IL 62259-0100

REMIT TO:



One Advantage, LLC
PO Box 23860
Belleville, IL 62223-0860

OneRadiology
Normal, Illinois
November 22, 2016

GHARRETT, DAVID
ID #: M38621
DOB: 07-24-87
Ordered by: Tindall, NP
Menard Correctional Center

SKULL 11-21-2016:

HISTORY: Hit in left eye. Large bump on right occipital area.

Five views were obtained. No fracture is seen. No bony abnormality is noted. There is mild haziness in the left maxillary antrum which may represent mucosal thickening. No air fluid level is noted in the sinuses.

IMPRESSION: No fracture is seen.

Signed _____


J. Foss, M.D.

Dic:11-22-2016

Films from Menard Correctional Center

M.D. Review
Date 11-30-16
Doctor W
Full Chart _____
See Patient _____
File ✓

received
11-29-16

[illegible]

[illegible]

MEDICATION ADMINISTRATION RECORD

BOSWELL PHARMACY SERVICES
814-629-1397 • Fax: 814-629-7644

EFFECTIVE DATES		MEDICATIONS		HOUR																															
Original Order	Discontinue			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
3/27/17	3/27/17	Effexor-ER 150mg po qhs dot																																	
1/27/16	3/27/17	Remeron 15mg po qhs dot																																	
3/27/17	3/27/17																																		
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Location	Initial	Signature	Initial	Signature	Initial	Signature	Initial	Signature	Initial	Signature
46239 N201										
Inmate Name and Number	Harrett, David M38621									
Date of Birth or Soc. Sec. No.	M38621									
Allergies	pen									
Facility	Menard									
Charting for	JAN 2017									
Through	JAN 2017									
Diagnosis	BOTHAC									

814-629-1397 • Fax: 814-629-7644

1994年10月1日

814-629-1397 • Fax: 814-629-7644

[illegible]

ILLINOIS DEPARTMENT OF CORRECTIONS
Offender Optometric Examination

Center

☐ Baseline ☐ Annual

Date: 12/19/16

Time: _____ a.m. ☐ p.m.

Offender Information:

Last Name

First Name

MI

ID#: 118621

Chief Complaint:

TRAUMA OS

MR. A. BARNES

CHIEF COMPLAINT: 1/2 TO 1/3 DEPT. 12-16

HPI: Location: _____ Duration: _____ Onset: _____ Severity: _____ Timing: _____ Modifiers: _____		Ocular History: <input type="checkbox"/> Cataracts: _____ <input type="checkbox"/> Glaucoma: _____ <input type="checkbox"/> Disease: _____ <input type="checkbox"/> Trauma/Surgery: _____ <input type="checkbox"/> Strabismus: _____ <input type="checkbox"/> Amblyopia: _____	
Medical History: <input type="checkbox"/> NIDDM <input type="checkbox"/> IDDM <input type="checkbox"/> Hypertension <input type="checkbox"/> Other: _____			
Visual Acuity: Uncorrected Distance: <input type="checkbox"/> OD 20/20 <input type="checkbox"/> OS 20/25- <input type="checkbox"/> OU 20/20 Uncorrected Near: <input type="checkbox"/> OD 20/ <input type="checkbox"/> OS 20/ <input type="checkbox"/> OU 20/			
Habitual Rx: OD _____ 20/ _____ Type: <input type="checkbox"/> SV <input type="checkbox"/> Bifocal OS _____ 20/ _____ Date: ____/____/____ Correction: OD _____ 20/ _____ Type: <input type="checkbox"/> SV <input type="checkbox"/> Bifocal OS _____ 20/ _____ Date: ____/____/____ Near: OD _____ 20/ _____ Type: <input type="checkbox"/> SV <input type="checkbox"/> Bifocal OS _____ 20/ _____ Date: ____/____/____		Pupil: <input checked="" type="checkbox"/> Round <input type="checkbox"/> Equal <input checked="" type="checkbox"/> Responds to Light/Accommodation <input type="checkbox"/> APD Motilities: <input type="checkbox"/> Full <input type="checkbox"/> Abnormal <input type="checkbox"/> Confrontational Fields: <input type="checkbox"/> Full <input type="checkbox"/> Abnormal Tonometry: <input checked="" type="checkbox"/> Applanation <input type="checkbox"/> Tonopen <input type="checkbox"/> NCT OD 25 OS 25 Time: _____	

Refraction Test:	Distance	Near	Slit Lamp Exam:	WNL	ABNL
Eso			Cornea		
Exo			Conjunctiva		
Tropia			Iris/Ant. Chamber		
Phoria			Lens		
Ortho			Lids/Lashes		

Ophthalmoscopy: WNL ABNL		Right	Left	Method: <input type="checkbox"/> Direct <input type="checkbox"/> BIO <input checked="" type="checkbox"/> 78D 90s <input type="checkbox"/> 3 mirror <input type="checkbox"/> Other: _____
Disc Vessels Macula Periphery Vitreous	Cup to disc: OD 0.4 OS 0.45			
Cup Depth: <input type="checkbox"/> Deep <input type="checkbox"/> Moderate <input type="checkbox"/> Shallow <input checked="" type="checkbox"/> PE 2.5%. Trop 1%				

Assessment/Plan: 1. TRAUMA OS
 2. _____
 3. _____
 4. PTC PPN
 5. _____

Medications Ordered: _____
 Eyeglasses Ordered: Frame: _____ Size: _____ Color: _____
 Rx: OD _____ Add: _____ Seg Height: _____
 OS _____ ☐ SV ☐ FT28 ☐ Reading Only PD _____

Print Doctor's Name

Doctor's Signature

Follow-Up:

Date

Distribution: Offender's Medical Record

DOC 0081 (Eff. 9/2002)

Printed on Recycled Paper

ILLINOIS DEPARTMENT OF CORRECTIONS

Offender Outpatient Progress Notes

Menard Center

Offender Information:

Gharrett

Last Name

David

First Name

ID#: M38621

MI

Date/Time	Subjective, Objective, Assessment	Plans
11/23/16	Med Furlough Clerk Note:	
9:40am	Pt has been scheduled for ER	
	Follow-up for ENT and	
	ophthalmology. Pt will go	
	on 12/16/16 @ 8:30 am to	
	Barnes Jewish Center for Outpatient	
	Health ENT clinic 4901 Forest Park	
	Ave., Floor 4, Ste 420, St. Louis, MO	
	Ph. 314-362-9100. Ophthalmology	
	Flu will be 12/16/16 @ 10:30 am	
	@ BSH South Eye Clinic, 517	
	S. Euclid, 1st Fl McMillan St. Louis, MO	
	Ph. 314-362-3431. No auth's	
	Issued yet.	
	Chinda Mall	
	Med Furlough Clerk	

ILLINOIS DEPARTMENT OF CORRECTIONS
Medical Special Services Referral and Report

Menard
 (Facility)

Offender's Name: Gharrett, David ID# M38621

Reason for Referral: ☐ Consult ☐ Non-Formulary Medications ☐ Medical Equipment
☒ Evaluation ☐ Management
☐ Procedure/service (specify) _____
☐ Other (specify) _____

Urgent: ☐ Yes ☒ No

Referred to: Ophthalmology

Rationale for Referral: _____

RYAN SUTTERER
 Print Referring Practitioner's Name

R. Sutterer
 Referring Practitioner's Signature

11-28-16
 Date

Report of Referral (Use Reverse Side, if necessary)

Findings: _____

Assessment: _____

Recommendations/Plans: _____

Print Practitioner's Name

Practitioner's Signature

Date

Facility Medical Director Use Only

I have reviewed the recommendations and:

☐ Approve.

☐ Deny or revise as indicated on the Notification of Medical Service Referral Denial or Revision, DOC 0255.

Print Facility Medical Director's Name

Facility Medical Director's Signature

Date

ILLINOIS DEPARTMENT OF CORRECTIONS
Medical Special Services Referral and Report

Menaud
(Facility)

Offender's Name: Gharrett, David ID# M38621

Reason for Referral: ☐ Consult ☐ Non-Formulary Medications ☐ Medical Equipment
☒ Evaluation ☐ Management
☐ Procedure/service (specify) _____
☐ Other (specify) _____

Urgent: ☐ Yes ☒ No

Referred to: ENT

Rationale for Referral: orbital fractures

Trost
Print Referring Practitioner's Name

[Signature]
Referring Practitioner's Signature

11/29/16
Date

Report of Referral (Use Reverse Side, if necessary)

Findings: _____

Assessment: _____

Recommendations/Plans: _____

Print Practitioner's Name

Practitioner's Signature

Date

Facility Medical Director Use Only
I have reviewed the recommendations and:

☐ Approve.

☐ Deny or revise as indicated on the Notification of Medical Service Referral Denial or Revision,
DOC 0255.

Print Facility Medical Director's Name

Facility Medical Director's Signature

Date

WEXFORD HEALTH SOURCES INCORPORATED

To: Site Medical Director & HSA

From: Utilization Management

DELIVERED DEC 02 2016

Date/Time: 12/02/2016 11:29:57

Subject: Inmate Name: GHARRETT, DAVID H

Inmate Number: M38621

Site: MENARD

Service:

99203 OFFICE/OUTPATIENT VISIT NEW

Authorization ID: 179595769

Based upon a review of the information provided, Service is Approved.

Comments:

Received a referral request for ENT & Ophthalmology for an inmate patient who went to ER on 11/21 for a closed fracture of orbital plate of ethmoid bone. He was hit behind while in his cell. DX left orbit fracture with inferior rectus entrapment. Dr. Ritz approved. Meets IQ for both requests.

From: _____
Dedicated Utilization Management

INFORMATION CONTAINED IN THIS DOCUMENT IS PRIVILEGED AND CONFIDENTIAL

Foster Plaza4 - 501 Holiday Drive - Pittsburgh, PA 15220

877-939-2884 or 800-353-8384 - Phone

412-937-9151 - Fax

WWW.WEXFORDHEALTH.COM

WEXFORD HEALTH SOURCES INCORPORATED

To: Site Medical Director & HSA

From: Utilization Management

DELIVERED JUL 3 2016

Date/Time: 12/02/2016 11:29:57

Subject: Inmate Name: GHARRETT, DAVID H

Inmate Number: M38621

Site: MENARD

Service:

99203 OFFICE/OUTPATIENT VISIT NEW

Authorization ID: 930675669

Based upon a review of the information provided, Service is Approved.

Comments:

Received a referral request for ENT & Ophthalmology for an inmate patient who went to ER on 11/21 for a closed fracture of orbital plate of ethmoid bone. He was hit behind while in his cell. DX left orbit fracture with inferior rectus entrapment. Dr. Ritz approved. Meets IQ for both requests.

From: _____
Dedicated Utilization Management

INFORMATION CONTAINED IN THIS DOCUMENT IS PRIVILEGED AND CONFIDENTIAL

Foster Plaza4 - 501 Holiday Drive - Pittsburgh, PA 15220
877-939-2884 or 800-353-8384 - Phone

412-937-9151 - Fax

WWW.WEXFORDHEALTH.COM

ILLINOIS DEPARTMENT OF CORRECTIONS

Offender Outpatient Progress Notes

Menard Center

Offender Information:

Charrett
Last NameDavid
First NameID#: M38421
MI

Date/Time	Subjective, Objective, Assessment	Plans
11/30/16	Med Furlough Clerk Note:	
12:15pm	Pt was presented to Collegial today by Dr. Trost for an ENT consult and an ophthalmology consult. Dr. Ritz, Wexford Unit, cancelled the case due to being sick. Dr. Ritz will review the cases.	
	Christos Maher	
	Med Furlough Clerk	
12/7/16	Med Furlough Clerk Note:	
120pm	Pt has been approved for the ENT consult and the ophthalmology consult.	
	Pt's were seen 12/6/16.	

Christos Maher
Med Furlough Clerk

DOC 0084 (Eff. 9/2002
(Replaces DC 7147))